Kansas Medical Assistance Program
PA Phone 800-933-6593
PA Pharmacy Fax 800-913-2229

Amerigroup
PA Pharmacy Phone 800-454-3730
PA Pharmacy Fax 844-512-8999

Sunflower
PA Pharmacy Phone 877-397-9526
PA Pharmacy Fax 866-399-0929

UnitedHealthcare
PA Pharmacy Phone 800-310-6826
PA Pharmacy Fax 866-940-7328

BENZODIAZEPINE PRIOR AUTHORIZATION FORM

Complete form in its entirety and fax to the appropriate plan's PA department.
For questions, please call the pharmacy helpdesk specific to the member's plan.

MEMBER INFORMATION

Name:	Medicaid ID:
Date of Birth:	Gender:

PRESCRIBER INFORMATION

Name:	Medicaid ID:	
NPI:	Phone:	Fax:
Address:	City, State, Zip Code:	

The following medications require Prior Authorization (PA). Medications requiring PA may have to meet clinical **and** Non-Preferred PA criteria before the claim may be considered for payment.

Please provide the required data for the specific drug being requested. Below is a list of links you may find helpful in determining the required information:

- Clinical PA criteria: http://www.kdheks.gov/hcf/pharmacy/pa_criteria.htm
- KS Preferred Drug List (PDL): http://www.kdheks.gov/hcf/pharmacy/download/PDLList.pdf
- Non-Preferred, PA Required PDL criteria: http://www.kdheks.gov/hcf/pharmacy/download/NonPreferred_PA_Criteria_for_PDL_Drugs.pdf

Note: Any area not filled out will be considered not applicable to this PA & may affect the outcome of this request.

Instructions to complete this form:

1. Complete **the Member/Prescriber Information** portion above and **Sections I and II** for **ALL** requests
2. Complete **Section III** if this request requires a **peer-to-peer review**.
3. Complete **Section IV** if this request is a **renewal.**
4. Prescriber - **Sign and date** the form prior to submission.

SECTION I: MEDICATION REQUESTED

Name of medication requested: _____

NDC	Strength	Dosage Form	Quantity	Directions for Use

SECTION II: CLINICAL INFORMATION – For ALL Requests

PLEASE NOTE –

- PA criteria only applies to oral dosage forms
- Do NOT use this form for Onfi® (clobazam) PA requests; refer to the Universal Clinical PA Form for Onfi®

1. Is this a new or renewal request for this medication?
   - ☐ New
   - ☐ Renewal – Proceed to section IV.

MULTIPLE CONCURRENT USE:

1. Does the patient have a documented seizure diagnosis? ☐ YES ☐ NO
   - If **YES**, no further documentation required. Skip to prescriber signature.
2. Is the patient receiving 3 or more different benzodiazepines concurrently within 30 days? ☐ YES ☐ NO
   - If **YES**, written peer-to-peer review is required. **Please complete Section III.**

DOSING LIMITATION:

1. Does the dose prescribed exceed the maximum daily dosing limit defined in Table 1 (page 2)? ☐ YES ☐ NO
   - If **YES**, written peer-to-peer review is required. **Please complete Section III.**
2. Does the prescriber ATTEST that he/she has reviewed the controlled substance prescriptions for this patient in the prescription drug monitoring program (PDMP) (A.K.A. K-TRACS) ☐ YES ☐ NO

PATIENT NAME:		MEDICAID ID:	

SECTION II (CONT.): CLINICAL INFORMATION – For ALL Requests

3. Is the patient taking a concurrent CNS depressant? ☐ YES – If yes, answer questions 3A & 3B ☐ NO – skip to section III
   - A. Is the concurrent CNS depressant an opioid? ☐ YES ☐ NO
   - B. Does the prescriber ATTEST that he/she has reviewed and addressed the increased risk of respiratory depression with the patient? ☐ YES ☐ NO

SECTION III: PEER-TO-PEER REVIEW

PLEASE NOTE:

- A written peer-to-peer review will be followed by a verbal peer-to-peer review with a health plan psychiatrist, medical director, or pharmacy director for approval if the written request is not approved.

(Provide any/all clinical rationale/justification for this request (i.e. documentation, chart notes, prior therapy, etc.)

☐ **PEER-TO-PEER WRITTEN:**

_____

_____

_____

_____

_____

☐ **PEER-TO-PEER VERBAL**

SECTION IV: RENEWAL CRITERIA

1. Is the patient stable? ☐ YES ☐ NO
2. Has the patient been seen by the prescribing provider within the past year? ☐ YES ☐ NO

PRESCRIBER SIGNATURE

☐ **I have completed all applicable boxes and attached any required documentation for review, in addition to signing and dating this form.**

_____ _____

Prescriber or authorized signature **Date**

Prior Authorization of Benefits is not the practice of medicine or the substitute for the independent medical judgment of a treating physician. Only a treating physician can determine what medications are appropriate for a patient. Please refer to the applicable plan for the detailed information regarding benefits, conditions, limitations, and exclusions. The submitting provider certifies that the information provided is true, accurate, and complete and the requested services are medically indicated and necessary to the health of the patient.

Note: Payment is subject to member eligibility. Authorization does not guarantee payment.

TABLE 1. BENZODIAZEPINE DOSING LIMITS

Drug	Max Daily Dose
Alprazolam	8mg
Chlordiazepoxide	300mg
Clonazepam	20mg
Clorazepate	90mg
Diazepam	40mg
Estazolam	2mg
Flurazepam	30mg
Lorazepam	10mg
Oxazepam	120mg
Quazepam	15mg
Temazepam	30mg
Triazolam	0.5mg